



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Dental Services

LIBRARY REFERENCE NUMBER: PROMOD00022
PUBLISHED: OCTOBER 22, 2020
POLICIES AND PROCEDURES AS OF JUNE 1, 2020
VERSION: 5.0

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: July 28, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 Published: August 9, 2016	Correction	FSSA and HPE
1.3	Policies and procedures as of April 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: March 21, 2017	CoreMMIS update	FSSA and HPE
2.0	Policies and procedures as of April 1, 2017 Published: August 1, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of April 1, 2018 Published: July 31, 2018	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of April 1, 2019 Published: December 12, 2019	Scheduled update	FSSA and DXC
5.0	Policies and procedures as of June 1, 2020 Published: October 22, 2020	Scheduled update <ul style="list-style-type: none"> • Edited text as needed for clarity • Added EVS limit responses to <i>Table 1 – Dental Limits Returned by the EVS and the EOBs for Related Claim Denials</i> • Updated the <i>Emergency Dental Services Covered under Package E and Package B</i> section with information about ESO Coverage with Pregnancy Coverage and billing instructions • Added exception for flexible-base partials and updated FFS PA contractor information in the <i>Prior Authorization for Dental Services</i> section 	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> Updated PA information for D5282 and D5283 in Table 7 – Covered Partial Dentures Added the Maxillofacial Prosthesis section Clarified billing information in the Physician-Administered Topical Fluoride Varnish section 	

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*Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the [IHCP Quick Reference Guide](#), available at in.gov/medicaid/providers.*

For updates to information in this module, see [IHCP Banner Pages and Bulletins](#), available at in.gov/medicaid/providers.

Introduction

Dental services are provided to Indiana Health Coverage Programs (IHCP) members as described in this module, subject to limits established for certain benefit packages. Dental services include diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession. These services include treatment of the teeth and associated structures of the oral cavity, disease, injury, or impairment that may affect the oral or general health of the individual. Dental services may be provided by general dentistry practitioners or by dental specialists, such as endodontists, oral surgeons, orthodontists, pediatric dentists, and periodontists.

Dental providers must bill for services as a dental claim, using the appropriate Current Dental Terminology (CDT^{®1}) procedure codes, as described in the [Billing and Reimbursement for Dental Services](#) section.

This module also includes information about physician-administered fluoride varnish billed as a professional claim; see the [Physician-Administered Topical Fluoride Varnish](#) section.

For information about EPSDT-related dental screening services, see the [Early and Periodic Screening, Diagnostic, and Treatment \(EPSDT\)/HealthWatch Services](#) module.

Member Eligibility Verification and Benefit Limit Information

Providers must verify eligibility at the time a member makes an appointment and again on the day of the appointment, before rendering the service. Providers can verify member eligibility through the Eligibility Verification System (EVS) options:

- [Provider Healthcare Portal](#), accessible from the home page at in.gov/medicaid/providers
- Interactive Voice Response (IVR) system at 1-800-457-4584
- 270/271 electronic transaction

These methods provide basic enrollment information for all IHCP members, including those enrolled through a managed care program (such as HIP, Hoosier Care Connect, or Hoosier Healthwise). For members enrolled in a fee-for-service program (such as Traditional Medicaid), additional information is also available. See the [Member Eligibility and Benefit Coverage](#) module for details.

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Benefit Limits

IHCP coverage for specific dental services is subject to the benefit limits described in the [Coverage, Limits, and Billing for Specific Dental Services](#) section.

To avoid claim denials, providers should verify that the member has not exhausted benefit limits before rendering services. The EVS options indicate whether the member has reached certain benefit limits, including limits related to the following dental services:

- Fluoride treatment
- Full mouth debridement
- Oral evaluations
- Prophylaxis
- Periodontal maintenance
- Periodontal scaling and root planing
- Sealant treatments
- Full-mouth or panoramic x-rays

Table 1 lists the specific benefit limit responses returned by the EVS, as well as the related explanation of benefits (EOBs) for claims that exceed those limits.

For benefit limit information that is **not** returned by the EVS, providers can contact the Written Correspondence Unit to request research of a member's FFS claim history for a given service. This request can be sent by secure correspondence as described in the [Provider Healthcare Portal](#) module.

Table 1 – Dental Limits Returned by the EVS and the EOBs for Related Claim Denials

EVS Limit Description	Corresponding EOB
6209 FULL MOUTH OR PANORAMIC X-RAYS LIMIT ONCE /3 YRS	Full-mouth or panorex x-rays limited to once every three years.
6211 PERIODIC/LIMITED ORAL EVAL LIMIT 1 EVERY 6 MONTHS	Periodic or limited oral evaluations are limited to one every 6 months.
6212 FLUORIDE TREATMENT LIMITED TO 1 EVERY 6 MONTHS	Indiana Health Coverage Program benefits allow payment for one topical application of fluoride every six (6) months. Fluoride treatments are limited to recipients 0 through 20 years of age.
6221 PERIODONTAL ROOT PLAN/SCAL 4 TX/2YRS NON-INSTITUTI	Reimbursement limited to four treatments of periodontal root planing/scaling every two (2) years for non-institutionalized recipients between the ages of three (3) and twenty (20) years.
6222 PERIODONTAL ROOT PLAN/SCALING, 4 TX PER 2 YRS INST	Reimbursement is limited to four treatments of periodontal root planing and scaling for institutionalized recipients every two (2) years regardless of age.
6223 PERIODONTAL ROOT PLAN 21 YR OR > 4/LIFE NON-INST	Periodontal root planing/scaling 4x/lifetime/non-institutional 21 years and older.
6225 ONE SEALANT PER TOOTH PER LIFETIME	Indiana Health Coverage Program benefits allow payment for one sealant treatment per premolars and molars per lifetime.

EVS Limit Description	Corresponding EOB
6235 PROPHY & PERIODTL MAINT NON-INSTI 21> LIM 1/12 MOS	Prophylaxis and periodontal maintenance is limited to one treatment every 12 months for non-institutional members 21 years or older.
6244 D4355 LIMITED TO ONCE EVERY 3 YEARS (DTL)	D4355 limited to once every 3 years (D4355 – Full mouth debridement to enable comprehensive evaluation and diagnosis)
6310 PROPHY & PERIODTL MAINT NON-INSTI 1-20 LIM 1/6 MOS	Prophylaxis and periodontal maintenance limited to one treatment every six months for non-institutionalized members over age twelve months to twenty-one years.

Emergency Dental Services Covered under Package E and Package B

The *Package E* benefit plan provides **emergency services only** (ESO) coverage for lawful permanent residents who meet eligibility guidelines. The *ESO Coverage with Pregnancy Coverage* benefit plan (also known as Package B) provides the same coverage as Package E, plus pregnancy benefits.

Preventative treatments such as sealants, prophylaxis, and fluoride treatments do not meet the definition of an emergency medical condition and are not covered under either benefit plan. Package E and Package B members who seek nonemergency dental services are responsible for the payment of such services. IHCP providers can bill the member for these services within the guidelines described in the *Charging Members for Noncovered Services* section of the [Provider Enrollment](#) module.

The *Omnibus Budget Reconciliation Act of 1990* (OBRA) defines an emergency medical condition as follows:

A medical condition of sufficient severity (including severe pain) that the absence of medical attention could result in placing the member's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of an organ or part.

With the assistance of the Dental Advisory Panel (DAP), the IHCP created a table of the CDT codes that are allowed for reimbursement under Package E and Package B. These codes are listed in the *Dental Procedure Codes Allowed for Package E and Package B Members* table in *Dental Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers. The listing of a code in this table does not eliminate the need for providers to maintain supporting documentation in the patient's records.

Radiographs are reimbursed under Package E and Package B only when the member presents with symptoms that warrant the diagnostic service.

For reimbursement under Package E or Package B, dental claims must include the following:

- On the *ADA 2012* paper claim form:
 - In field 2: Predetermination/Preauthorization Number, enter the word **Emergency** to indicate that the claim is for an emergency situation.
 - In field 29: Procedure Code, enter only appropriate procedure codes that have been designated by the IHCP as emergency dental services.
 - If applicable, in field 45: Treatment Resulting From, indicate if the treatment is the result of an occupational illness or injury, an auto accident, or other accident.
- On the Portal dental claim:
 - In the *Claim Information* panel in Step 1, select the Emergency box to indicate that the claim is for an emergency situation.

- Also in the *Claim Information* panel in Step 1, if the treatment is a result of an occupational illness or injury, auto accident, or other accident, select the appropriate option from the drop-down menu in the Accident Related field.
- In the *Service Details* panel in Step 3, in the Procedure Code field, enter only appropriate procedure codes that have been designated by the IHCP as emergency dental services.

Prior Authorization for Dental Services

The following dental services are subject to prior authorization (PA) for medical necessity:

- Periodontal surgery
- Space maintenance for children under 3 years of age or if permanent teeth are missing
- Orthodontics
- Dentures (complete and partial) for members 21 years of age or older
 - Flexible-base partials require PA for all ages
- Repairs and relines of dentures (complete and partial) for members 21 years of age or older
- Frenulectomy (frenectomy or frenotomy)
- General anesthesia for members 21 years of age or older
- IV sedation for members 21 years of age or older

The IHCP returns PA requests to the provider if the requests are submitted for any other dental services. Prior authorization **does not override** a noncovered status on a dental code; therefore, a dental provider should **not** submit a PA request for a noncovered procedure code. The IHCP provides no reimbursement for ineligible members or for noncovered services. PA does not guarantee payment.

PA for FFS dental services may be requested through the IHCP Provider Healthcare Portal (Portal), or by mail or fax using the appropriate PA request form, available on the [Forms](#) page at in.gov/medicaid/providers. For orthodontic PA requests, use the *IHCP Prior Authorization Request Form* (universal PA form). For all other dental PA requests, use the *IHCP Prior Authorization Dental Request Form*. For information about completing and submitting PA requests, see the [Prior Authorization](#) module.

For questions about dental PA for fee-for-service members, call 1-800-457-4584, option 7. See the [IHCP Quick Reference Guide](#) for additional contact information, including for managed care members.

Billing and Reimbursement for Dental Services

The IHCP reimburses dental services using a combination of a maximum fee pricing methodology and manual pricing methodology. Providers must use CDT procedure codes to bill dental services. Providers must submit dental claims on the dental claim (*American Dental Association 2012 Dental Claim Form [ADA 2012]*, Portal dental claim, or 837D transaction). See the [Claim Submission and Processing](#) module for instructions for completing and submitting a dental claim. CDT codes and related reimbursement information are included in the Professional Fee Schedule, accessible from the [IHCP Fee Schedules](#) page at in.gov/medicaid/providers.

For information about billing and reimbursement related to dental procedures performed in a hospital or ambulatory surgical center (ASC), see the [Services Provided outside the Dental Office](#) section.

Note: If a member wants a service that is noncovered by the IHCP, such as a type of denture that does not meet coverage guidelines, IHCP providers can bill the member for the services within the guidelines described in the Charging Members for Noncovered Services section of the [Provider Enrollment](#) module.

Area of Oral Cavity

The Area of Oral Cavity field on the dental claim is evaluated for duplication when providers bill CDT codes that are based on dental quadrants. For example, providers should indicate the appropriate dental quadrant for each line item when billing multiple units of D4341 – *Periodontal scaling and root planing – four or more teeth per quadrant*. If a provider bills multiple units of D4341 with the same area of oral cavity, or without identifying the area of oral cavity, the IHCP pays the first line item and denies the second and all subsequent D4341 line items with the EOB 5000 or 5001– *This is a duplicate of another claim*.

Table 2 indicates the two-digit codes for each area. If the CDT code does not refer to a quadrant or arch, or if the specific quadrant or arch in question is already identified by the CDT code itself, the Area of Oral Cavity field should be left blank.

Table 2 – Area of Oral Cavity Codes

Code	Area
L	Left
R	Right
00	Entire oral cavity
01	Maxillary area
02	Mandibular area
09	Other area of oral cavity
10	Upper right quadrant
20	Upper left quadrant
30	Lower left quadrant
40	Lower right quadrant

Tooth Numbering System

For certain CDT procedure codes, the IHCP requires that the tooth number (or letter) be entered in the service line. For a list of applicable CDT codes, see *Dental Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers. The IHCP accepts only one tooth number per service line.

The IHCP recognizes the Universal/National Tooth Designation System (1–32 for permanent dentition and A–T for primary dentition), as described in the CDT reference manual.

Supernumerary Tooth Designations

The IHCP has adopted the ADA tooth designations for supernumerary teeth.

For permanent dentition, supernumerary teeth are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar.

Table 3 – Supernumerary Tooth Designations for Permanent Dentition

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
“Super” #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
“Super” #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

For primary dentition, supernumerary teeth are identified by the placement of the letter “S” following the letter identifying the adjacent primary tooth (supernumerary “AS” is adjacent to “A”).

Table 4 – Supernumerary Tooth Designations for Primary Dentition

Tooth #	A	B	C	D	E	F	G	H	I	J
“Super” #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Tooth #	T	S	R	Q	P	O	N	M	L	K
“Super” #	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

Supernumerary tooth services, such as extractions, are billed using the appropriate CDT procedure code with the appropriate supernumerary tooth number or letters. No attachment is required.

Tooth Surface Codes

For any claim detail billed using a procedure code that requires a tooth surface, as indicated in the CDT description of the code, providers must bill using the appropriate number of valid tooth surface codes. Table 5 provides valid tooth surface codes.

Table 5 – Valid Tooth Surface Codes

Anterior Teeth		Posterior Teeth	
D	(Distal)	B	(Buccal)
F	(Facial)	D	(Distal)
I	(Incisal)	L	(Lingual)
L	(Lingual)	M	(Mesial)
M	(Mesial)	O	(Occlusal)

Table 6 provides a current list of all procedure codes that require a tooth surface for billing, as well as the minimum number of tooth surface codes required for each procedure code.

Table 6 – Current Procedure Codes Requiring a Tooth Surface Code

Procedure codes that require <i>one</i> tooth surface code	Procedure codes that require <i>two</i> tooth surface codes	Procedure codes that require a minimum of <i>three</i> tooth surface codes	Procedure codes that require a minimum of <i>four</i> tooth surface codes
D2140	D2150	D2160	D2161
D2330	D2331	D2332	D2335*
D2391	D2392	D2393	D2394
* Providers must bill D2335 with four surfaces or with an I , indicating incisal angle. Providers must maintain appropriate supporting documentation in the dental or medical chart, because dental records are subject to postpayment review.			

Coverage, Limits, and Billing for Specific Dental Services

This section provides coverage, limits, and billing procedures for the more commonly used dental services. IHCP coverage for any particular service is subject to limits established for certain benefit plans. For age restrictions attached to certain dental procedure codes, see the Professional Fee Schedule, accessible from the [IHCP Fee Schedules](#) page at in.gov/medicaid/providers.

Behavior Management Services

The IHCP limits reimbursement of CDT code D9920 – *Behavior management, by report* to once per member, per date of service. Documentation supporting the medical necessity, type, and appropriateness of dental behavior management services must be retained in the member’s chart and is subject to postpayment review.

Dentures – Complete and Partial

The IHCP covers complete dentures (D5110 and D5120) and partial dentures for members of all ages, subject to medical necessity and (for members 21 years of age and older) prior authorization. See the [Covered Partial Denture Types](#) section for covered codes for partial dentures. The IHCP covers immediate dentures (D5130 and D5140) only for members 21 years of age and older. The IHCP *does not* reimburse an additional amount for immediate dentures beyond the current denture allowance.

The IHCP waives the 60-day waiting period between the date of the last extraction and the date of the initial impression. The IHCP does not reimburse for additional charges related to furnishing the dentures before the 60-day waiting period. Providers can hold the patient responsible for these additional charges if the provider gives the patient advance notice and documents this in the record as described previously.

The IHCP provides reimbursement for dentures once every 6 years, if medically necessary; however, providers must obtain PA for members 21 years old and older. Though PA is not required for members under age 21, medical necessity should be included in the patient chart.

The IHCP can require the member to use the most cost-effective treatment instead of the specifically requested treatment, as long as the cost-effective procedures meet the medically necessary needs of the member.

The service of providing dentures to any patient is not complete until the completed denture has been delivered to the patient. The date of the provision of the finished product is the date of service that must be used for claims filing and must be supported by record documentation. The provider must bill the IHCP according to when the services are rendered. The IHCP requires that provider records be maintained in accordance with 405 IAC 1-5-1. Per 405 IAC 1-5-1(b)(4), the medical record must contain the date when the service was rendered. In addition, according to 405 IAC 1-1-4, denial of claim payment can occur if the services claimed are not documented in accordance with 405 IAC 1-5-1.

Prior Authorization and Medical Necessity

The IHCP requires PA for dentures for members 21 years of age and older; requests are reviewed for medical necessity. The IHCP considers eight posterior teeth in occlusion – four maxillary and four mandibular teeth in functional contact with each other – to be adequate for functional purposes. The IHCP does not approve requests for partial dentures that replace only anterior teeth. The IHCP considers anterior tooth replacement purely an aesthetic or cosmetic concern and not medically necessary.

A service is “medically necessary” when it meets the definition of “medically reasonable and necessary service” as defined in 405 IAC 5-2-17. The IHCP determines medical necessity by reviewing documentation submitted by the provider to support the functional and medical needs of the patient. When submitting the PA request (either via the Portal or using the *IHCP Prior Authorization Dental Request Form*), the dentist should complete all applicable information and include all descriptions necessary to create a complete clinical picture of the patient and the need for the request. The request should include any information about bone or tissue changes due to shrinkage, recent tooth loss, weight loss, bone loss in the upper or lower jaw, recent sickness or disease, or changes due to physiological aging. If the member’s primary source of nutrition is parenteral or enteral nutritional supplements, a plan of care to wean the member from the nutritional supplements must be included with the request. If the prosthesis is 6 years old or older, dentists should indicate on the PA request whether the useful life of the existing prosthesis can be extended by a repair or a reline. Dentists must also include their office telephone number on the PA request, in case the PA analyst has questions.

Note: Prior authorization is not required for members younger than 21 years of age; however, the provider must maintain documentation to support the medical necessity of the services and type of denture or partial provided. Providers are responsible for maintaining supporting documentation within the member’s medical record for members of all ages.

The dental provider must submit documentation supporting the need for dentures (full or partial), including the following:

- The member is edentulous and unable to masticate properly (fewer than eight posterior teeth are in occlusion).
 - If a member has been edentulous for 3 or more years, providers must submit documentation explaining why they are submitting a request for dentures at this time. The documentation must include a favorable prognosis, an analysis of the oral tissue status (such as muscle tone, ridge height, and muscle attachments), and justification of the reason the patient has been without a prosthesis.
 - If the provider’s request indicates that the member has not worn an existing prosthesis for 3 or more years and the provider documents no mitigating circumstances warranting the authorization of a new prosthesis, the IHCP denies the PA request.
- The member is physically and psychologically able to wear and maintain the prosthesis.

For **replacement** dentures, in addition to the preceding items, the provider must also submit documentation that the existing prosthesis requires replacement due to one of the following reasons:

- The existing prosthesis is 6 years old or older, beyond repair, and cannot be relined.
- The base is ill-fitting, the teeth are worn, and the prosthesis cannot be relined.
- There is severe loss of vertical dimension, and the prosthesis cannot be relined.
- The prosthesis has been lost, destroyed, or stolen. (Providers must submit an explanation of the circumstances; otherwise, the IHCP denies the request.)

Covered Partial Denture Types

See Table 7 for coverage and PA guidelines for partial dentures.

Table 7 – Covered Partial Dentures

Type of Denture	Procedure Codes	Coverage Guidelines
Resin partial dentures	D5211 and D5212	Covered. Prior authorization is required for members 21 years of age and older.
Cast-metal partial dentures	D5213 and D5214	Covered only for members with facial deformity due to congenital, developmental, or acquired defects. The need for a cast-metal partial must be documented in the member's medical record for all members who require this type of denture. Prior authorization is required for members 21 years of age and older, and the PA request must include specific reasons for the request.
Flexible-base partial dentures	D5225 and D5226	Covered only for members with one of the following: <ul style="list-style-type: none"> • A documented allergic reaction to other denture materials • A facial deformity due to congenital, developmental, or acquired defects (such as cleft palate conditions) that require the use of a flexible-base partial instead of an acrylic or cast-metal partial The need for a flexible-base partial must be documented in the member's medical record for all members who require this type of denture. Prior authorization is required for members of all ages, and the PA request must include specific reasons for the request.
Removable unilateral partial denture – one piece cast metal	D5282 and D5283	Covered. Prior authorization is required for members 21 years of age and older. (For PA requests before March 4, 2020, PA was required for all ages.)

Repairs, Relines, and Rebases of Dentures

The IHCP covers laboratory relines, chairside relines, repairs to dentures, and repairs to complete or partial dentures only when the reline or repair extends the useful life of a medically necessary denture that is 6 or more years old. The IHCP does not cover rebases (D5710–D5721).

Providers must obtain PA for members 21 years of age and older for relines and repairs to complete or partial dentures. To be approved, the provider should indicate on the PA request that the individual is

eligible for a new prosthesis, but a repair or reline will extend the useful life of the existing prosthesis. Providers must use the following codes for claims and PA requests for relines and repairs:

- Repairs to dentures – D5510 and D5520
- Repairs to partial dentures – D5610–D5660
- Chairside relines – D5730–D5741 (PA is not required)
- Laboratory relines – D5750–D5761

PA is not required for members younger than 21 years of age; however, documentation to support medical necessity must be maintained by the provider in the medical record.

For research of a member's FFS claim history to determine the age of a denture, contact the Written Correspondence Unit as described in the [Benefit Limits](#) section.

Extractions

The IHCP covers extraction of teeth when the procedure is medically necessary and the diagnosis supports the extraction.

The IHCP allows only one tooth number per service line for dental extractions. A provider submitting a claim for CDT codes D7140 – *Extraction, erupted tooth or exposed root (elevation and/or forceps removal)* or D7111 – *Extraction coronal remnants – deciduous tooth* must indicate the tooth number for each tooth extracted on a separate service line in field 27 on the ADA 2012 claim form or in the equivalent field of the electronic dental claim.

The IHCP pays 100% of the maximum allowed amount or the billed amount, whichever is less, for the initial extraction. For multiple extractions within the same quadrant on the same date of service, the IHCP pays 90% of the maximum allowed amount for procedure code D7140 or the billed amount, whichever is less.

D7111 will also cut back to 90% of the allowed amount when billed with multiple units or with D7140.

*Note: Sutures are considered a part of a general extraction. Therefore, D7910–D7912 (sutures) should not be billed for the same date of service as D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, or D7251 (extractions), except when sutures are needed **unrelated** to the extraction. If this situation occurs, sutures are payable separately from the extraction. Providers must submit written documentation with the claim to support that the suture is unrelated to the extraction being billed (for example, the suture is in another part of the mouth).*

Fluoride Treatment (Topical)

According to 405 IAC 5-14-4, reimbursement is available for one topical application of fluoride every 6 months for members from first tooth eruption to 21 years of age. Topical applications are not covered for members 21 years of age or older.

Table 8 summarizes these reimbursement limits.

Table 8 – Topical Fluoride Treatment Benefit Limits

Age	Limit
From first tooth eruption until 21st birthday	One application every 6 months
21 years of age or older	No coverage for fluoride

Topical fluoride includes varnish, gel, or foam. Procedure code D1208 – *Topical application of fluoride – excluding varnish* is billed for members 0–20 years of age.

The IHCP reimburses for procedure code D1206 – *Topical application of fluoride varnish* for members 1–20 years of age who have a moderate to high risk of dental caries.

For information about fluoride varnish administered by a physician and billed on the professional claim, see the [Physician-Administered Topical Fluoride Varnish](#) section.

Frenulectomy (Frenectomy or Frenotomy)

A frenulectomy (frenectomy or frenotomy) (D7960) in the dental setting is a covered IHCP service. There is a restriction of two units per date of service.

Prior authorization is required for a frenulectomy. Medical necessity must be established, which may include breast-feeding issues, ankyloglossia (tongue-tie), tissue pull, or diastema.

Maxillofacial Surgery

Prior authorization is required for maxillofacial surgery. IHCP providers may be required, based on the facts of the case, to obtain a second or third opinion substantiating the medical necessity or approach for maxillofacial surgery related to diseases and conditions of the jaws and contiguous structures. The second opinion is required regardless of the surgical setting in which the surgery is to be performed, such as ambulatory surgical center, hospital, or clinic.

Maxillofacial Prosthesis

For dates of service on or after May 14, 2020, the IHCP covers CDT code D5999 – *Unspecified maxillofacial prosthesis*. Prior authorization is required.

PA for the coverage of oral appliance therapy is subject to the following:

- A face-to-face evaluation must be completed by a provider before a sleep test, to assess the member for obstructive sleep apnea.
- The sleep test must meet one of the following:
 - An apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) that is equal to 5 or less than 14 events per hour
 - AHI or RDI is greater than or equal to 15 events per hour with a minimum of 30 events and:
 - Patient experiencing trial and failure of a continuous positive airway pressure (CPAP) machine
 - AHI or RDI is equal to or greater than 30 events per hour and:
 - Patient experiencing trial and failure of a CPAP machine
- The patient has confirmed obstructive sleep apnea.
- The device must be ordered by a provider following review of the report of the sleep test.
- Referral must be from a physician to the dentist.
- The device is provided and billed by a dentist.

The dental provider should maintain sleep study results in the patient's file.

Code D5999 is reimbursed at 90% of billed charges. A cost invoice or manufacturer's suggested retail price (MSRP) must be submitted with the claim.

Oral Evaluations

The IHCP limits reimbursement of procedure codes D0150 – *Comprehensive oral evaluation – New or established patient* and D0160 – *Detailed and extensive oral evaluation – Problem focused, by report* to one unit of either D0150 or D0160 per provider per member lifetime. In addition, members are limited to a total of two units per year for any combination of these two codes.

The IHCP limits procedure code D0145 – *Oral evaluation for a patient under three years of age and counseling with primary caregiver* to one per year, per member, any provider.

The IHCP limits procedure code D0120 – *Periodic oral evaluation – Established patient* to one every 6 months, per member, any provider.

The IHCP does not subject procedure code D0140 – *Limited oral evaluation – Problem focused* to unit limits; however, providers should use the code as defined in the CDT reference manual. This type of evaluation is for patients who have been referred for a specific problem, such as dental emergencies, trauma, acute infections, conditions requiring immediate medical attention, and so forth. Providers should not use D0140 for periodic oral evaluations or other types of evaluations.

Table 9 summarizes these reimbursement limits for oral evaluation codes.

Table 9 – Oral Evaluation Benefit Limits

Dental Code	Code Description	Unit Limit
D0120	Periodic oral evaluation – Established patient	One every 6 months, per member
D0140	Limited oral evaluation – Problem focused	None
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	One per year, per member
D0150	Comprehensive oral evaluation – New or established patient	One per lifetime, per member, per provider*
D0160	Detailed and extensive oral evaluation – Problem focused, by report	One per lifetime, per member, per provider*
*Note: The IHCP allows members up to two units per year for any combination of procedure codes D0150 and D0160, but the two units cannot be from the same provider. A particular provider can bill either D0150 or D0160 only one time per member per lifetime.		

Dental evaluations are closely monitored by the IHCP and are subject to recoupment. Documentation in the dental and medical records must support that the provider rendered the oral evaluation in compliance with the procedure definition for the dental code being used.

Note: Oral exams and routine cleanings for residents of State-operated group homes are included in the per diem rate when performed at the group home.

Orthodontics

The IHCP covers orthodontic procedures only for members 20 years old and younger and only for cases of craniofacial deformities, whether congenital or acquired.

The IHCP allows for phased orthodontic treatment that incorporates both an interceptive phase and a comprehensive phase, with specific objectives at various stages of dentofacial development. For example, the use of an expander, partial fixed appliances, and a headgear may be stage one of a two-stage treatment.

In this situation, placement of full-arch fixed appliances generally will be stage two of a two-stage phased treatment plan.

The IHCP covers the following orthodontic treatments:

- **Limited orthodontic treatment** is defined as treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive treatment. The IHCP does not accept limited orthodontic treatment as part of a multiphased treatment plan. Limited orthodontic treatment codes are as follows:
 - D8010 – *Limited orthodontic treatment of the primary dentition*
 - D8020 – *Limited orthodontic treatment of the transitional dentition*
 - D8030 – *Limited orthodontic treatment of the adolescent dentition*
 - D8040 – *Limited orthodontic treatment of the adult dentition*
- **Interceptive orthodontic treatment** is defined as treatment for procedures to lessen the severity or future effects of a malformation and to eliminate its cause. It can be considered an extension of preventive orthodontics that may include localized tooth movement. Such treatment may occur in the primary or transitional dentition. An example might be use of a palatal expander to correct a damaging one-sided crossbite. Interceptive orthodontic treatment codes are as follows:
 - D8050 – *Interceptive orthodontic treatment of the primary dentition*
 - D8060 – *Interceptive orthodontic treatment of the transitional dentition*
- **Comprehensive orthodontic treatment** is defined as treatment of the dentition as a whole. Treatment usually, but not always, uses fixed orthodontic appliances or braces. Comprehensive treatment includes appliances, retainers, and repair or replacement of retainers; these may not be separately billed if comprehensive treatment is rendered. Comprehensive orthodontics may incorporate treatment phases focusing on specific objectives at various stages of dentofacial development. Comprehensive orthodontic treatment codes are as follows:
 - D8070 – *Comprehensive orthodontic treatment of the transitional dentition*
 - D8080 – *Comprehensive orthodontic treatment of the adolescent dentition*
 - D8090 – *Comprehensive orthodontic treatment of the adult dentition*

Prior Authorization Requirements

PA is required for all orthodontic services. When submitting a PA request for orthodontic services by mail or fax, providers must use the *Indiana Health Coverage Programs Prior Authorization Request Form* (universal PA form), available on the [Forms](#) page at in.gov/medicaid/providers. The dental PA request form should **not** be used for submitting orthodontic PA requests. For authorization requests submitted through the Portal, select **Orthodontics** as the service type to ensure proper processing.

PA requests for limited, interceptive, or comprehensive orthodontic treatment are reviewed on a case-by-case basis. A PA request for removable or fixed-appliance therapy must show that the patient meets the criteria outlined in this policy and has a harmful habit in need of correction.

Phased Orthodontic Treatment

The IHCP accepts PA requests for phased orthodontic treatment. The provider must submit a step-by-step treatment plan with the treatment phase and length of treatment specified. One PA is issued per phase of treatment, and the PA lasts for the length of the treatment specified.

The IHCP will reimburse for a maximum of two phases of orthodontic treatment: one interceptive phase and one comprehensive phase. When requesting multiple phases of orthodontic treatment, providers should use the following guidance:

- **Phase 1** – Request the most appropriate *interceptive* orthodontic code (D8050 or D8060).
- **Phase 2** – Request the most appropriate *comprehensive* orthodontic code (D8070, D8080, or D8090).

All requests for PA must include detail on time frames and the expectations of both phases of treatment.

The IHCP does not accept limited orthodontic treatment codes (D8010, D8020, D8030, and D8040) as part of the treatment plan for phased orthodontic treatment. By definition, limited orthodontic treatment has a specific, limited objective and is not part of a multiphased treatment approach.

Medical Necessity Requirements for Orthodontic PA

Members meet the criteria for medical necessity for orthodontic care when it is part of a case involving treatment of craniofacial anomalies, malocclusion caused as the result of trauma, or a severe malocclusion or craniofacial disharmony that includes, but is not limited to:

- Overjet equal to or greater than 9 mm
- Reverse overjet equal to or greater than 3.5 mm
- Posterior crossbite with no functional occlusal contact
- Lateral or anterior open bite equal to or greater than 4 mm
- Impinging overbite with either palatal trauma or mandibular anterior gingival trauma
- One or more impacted teeth with eruption that is impeded (excluding third molars)
- Defects of cleft lip and palate or other craniofacial anomalies or trauma
- Congenitally missing teeth (extensive hypodontia) of at least one tooth per quadrant (excluding third molars)

The member's diagnosis must include information descriptive of facial and soft tissue, skeletal, dental/occlusal, functional, and applicable medical or other conditions. Diagnostic records required to establish medical necessity include:

- Panoramic radiograph
- Cephalometric radiograph
- Intraoral and extraoral photos

Members with malocclusions associated with a craniofacial anomaly must be diagnosed by a member of a craniofacial anomalies team recognized and endorsed by the American Cleft Palate-Craniofacial Association (ACPA), presumably an orthodontist, and treated by an orthodontist who may or may not be a member of a recognized craniofacial anomalies team.

Members with malocclusions not associated with a craniofacial anomaly may be diagnosed and treated by any orthodontist, whether a member of a recognized craniofacial anomalies team or not. The treating provider is not required to be associated with a recognized craniofacial anomalies team.

Billing and Reimbursement

The IHCP **does not reimburse** for the following procedure codes; these services are included in the reimbursement for orthodontic treatment and are not separately reimbursed:

- D8660 – Pre-orthodontic treatment examination to monitor growth and development
- D8670 – Periodic orthodontic treatment visit
- D8680 – Orthodontic retention (Removal of appliances, construction and placement of retainer(s))
- D8681 – Removable orthodontic retainer adjustment
- D8690 – Orthodontic Treatment (Alternative billing to a contract fee)
- D8691 – Repair of orthodontic appliance
- D8692 – Replacement of lost or broken retainer
- D8693 – Re-cement or re-bond fixed retainer
- D8694 – Repair of fixed retainers, includes reattachment
- D8999 – Unspecified orthodontic procedure, by report

The IHCP expects patients to continue treatment with the same practitioner for the period of treatment time that is prior authorized. In the unlikely event that the patient must discontinue treatment with one practitioner and begin treatment with another practitioner, the practitioner continuing the treatment must submit a new PA request. The first practitioner must refund part of the reimbursement to the IHCP. Generally, one-third of the reimbursement is for the evaluation and treatment plan, and two-thirds of the reimbursement is for the actual treatment. Based on the time remaining in the treatment rendered by a new practitioner, the first practitioner must prorate the amount to be refunded to the program.

Patient Records Requirements

Providers must maintain documentation for orthodontic services in the patient's dental or medical record, as required by *405 IAC 1-1.4-2*, which includes:

- Medicaid records must be of sufficient quality to fully disclose and document the extent of services provided to individuals receiving Medicaid assistance.
- Medicaid records must be documented at the time the services are provided or rendered, and prior to associated claim submission.
- All providers shall maintain, for a period of 7 years from the date Medicaid services are provided to a member, such medical and/or other records, including x-rays, as are necessary to fully disclose and document the extent of the services provided. A copy of the claim form that has been submitted by the provider for reimbursement is not sufficient documentation, in and of itself, to comply with this requirement. Providers must maintain records that are independent of claims for reimbursement.

Palliative Treatment of Facial Pain for Emergency Dental Services

405 IAC 5-14-13 limits palliative treatment of facial pain, such as an abscess, incision, and drainage, to emergency treatment only. Providers can bill CDT code D0140 – *Limited oral evaluation – problem focused* for the emergency exam. If the specific procedure performed for the palliative care has a corresponding CDT code, providers should also bill that code, rather than billing the code for palliative care. The IHCP does not cover CDT code D9110 – *Palliative (emergency) treatment of dental pain – Minor procedure*.

For example, if a provider performs an emergency incision and drainage of an abscess or intraoral soft tissue procedure, the provider should bill code D7510 for the procedure with code D0140 for the exam.

To specify that the services performed were for emergency care, providers must write the word “Emergency” in field 2 of the *ADA 2012 Dental Claim Form* dental claim form or select the Emergency box in the *Claim Information* panel in Step 1 of the Portal dental claim submission. All services are subject to postpayment review, and documentation must support medical necessity for the services performed.

Periodontal Maintenance

The IHCP covers HCPCS code D4910 – *Periodontal maintenance* for members over 3 years of age. For members over 3 years old and under 21 years old, and for all institutionalized members, coverage is limited once every 6 months. For noninstitutionalized members 21 years old and older, coverage is limited to once every 12 months. Table 10 summarizes these reimbursement limits for periodontal maintenance.

Table 10 – Periodontal Maintenance Benefit Limits

Age	Limits
Under 3 years old	No coverage for periodontal maintenance
At least 3 years old but under 21 years old	Once every 6 months per member
21 years and older	Once every 12 months per month
Institutionalized members (all ages)	Once every 6 months

For reimbursement of D4910, at least one unit of a qualifying service must have been billed for the member. For a list of applicable codes, see the *Qualifying Dental Service Required before Periodontal Maintenance* table on *Dental Services Codes*, accessible from the [Codes Sets](#) page at [in.gov/medicaid/providers](#). The date of service for the first qualifying service must be at least 6 months before the date of service for the periodontal maintenance.

Note: Providers are not allowed to bill for prophylaxis for members who are receiving periodontal maintenance. See the [Prophylaxis](#) section for details.

Periodontal Root Planing and Scaling and Full-Mouth Debridement

The IHCP covers periodontal root planing and scaling for members over 3 years old. For members over 3 years old and under 21 years old, and for all institutionalized members, coverage is limited to four units every 2 years. For noninstitutionalized members 21 years old and older, the IHCP limits periodontal root planing and scaling to four units per lifetime. Providers can perform the service for all four quadrants on the same date of service.

Table 11 summarizes these reimbursement limits for root planing and scaling services.

Table 11 – Periodontal Root Planing and Scaling Benefit Limits

Age	Limits
Under 3 years old	No coverage for root planing and scaling
At least 3 years old but under 21 years old	Four units every 2 years
21 years and older	Four units per lifetime
Institutionalized members (all ages)	Four units every 2 years

When IHCP providers submit claims for D4341 – *Periodontal scaling and root planing – four or more teeth per quadrant* or D4342 – *Periodontal scaling and root planing – one to three teeth per quadrant*, they must submit documentation (periodontal charting) supporting the medical necessity of providing this service. The following requirements apply:

- Documentation must indicate that the member has periodontal disease by showing pocket markings or evidence of attachment loss and showing that the procedure was necessary for the removal of cementum and dentin that is rough, permeated by calculus, or contaminated with toxins or microorganisms.
- **The date of the root planing and scaling must be written on the periodontal chart next to the quadrant.**
- **The attachment must also include the member's name. If the member's name and date of service are not on the attachment, the claim will deny for EOB 4019 – *Attachment required for service rendered. Please verify and resubmit.***
- The IHCP does not require radiographs documenting the periodontal disease with the claim submission, but radiographs must be part of the dental record and maintained in the dentist's office.

When billing for multiple units of D4341 or D4342, the quadrants must be indicated for each service line, as described in the [Area of Oral Cavity](#) section.

Full-mouth debridement is intended for patients with excessive plaque or calculus that inhibits the dental professional's ability to perform comprehensive oral evaluations. It is only indicated in situations when the patient has not had a dental visit for several years. The IHCP limits coverage of full-mouth debridement services (D4355 – *Full mouth debridement to enable comprehensive evaluation and diagnosis*) as follows:

- Limited to once per 3 years per member
- Limited to one unit per date of service

Note: Prophylaxis (D1110 or D1120) should not be billed for the same date of service as periodontal root planing and scaling or full-mouth debridement. Reimbursement of prophylaxis is included in the reimbursement for root planing and scaling or full-mouth debridement.

Periodontal Surgery

Periodontal surgery is a covered IHCP service for cases of drug-induced periodontal hyperplasia. Documentation in the patient's record must substantiate that the service was provided for drug-induced periodontal hyperplasia.

Prophylaxis

The IHCP covers prophylaxis for members over 12 months of age. For members from 12 months of age to their 21st birthday, and for institutionalized members of all ages, coverage is limited to once every 6 months. For noninstitutionalized members 21 years old and older, coverage is limited to once every 12 months. Members under 12 months of age are not eligible for prophylaxis unless medical necessity can be established.

Table 12 summarizes these reimbursement limits for prophylaxis.

Table 12 – Prophylaxis Benefit Limits

Age	Limits
Under 12 months	No coverage for prophylaxis service unless medical necessity can be established
12 months up until 21st birthday	One unit every 6 months
21 years of age or older	One unit every 12 months
Institutionalized members (all ages)	One unit every 6 months

If an adult prophylaxis is supplied, the provider can bill CDT code D1110 – *Prophylaxis, adult* for members 12 years old and up. Providers use code D1120 – *Prophylaxis, child* to bill for child prophylaxis for members under age 12.

Prophylaxis is considered a preventative procedure for healthy tissue, whereas periodontal services are therapeutic procedures. Adult or child prophylaxis services (D1110 or D1120) should not be billed on the same date of service as periodontal services (D4341, D4342, or D4355). Additionally, providers are not allowed to bill for prophylaxis for members receiving periodontal maintenance, as follows:

- For members under age 21 and for institutionalized members, there must be at least **6 months** between a date of service for periodontal maintenance and a date of service for prophylaxis.
- For noninstitutionalized members age 21 and older, there must be **12 months** between a date of service for periodontal maintenance and a date of service for prophylaxis.

Note: For residents of a nursing home or a group home, the IHCP will pay for prophylaxis only once every 6 months. Oral exams and routine cleanings for residents of State-operated group homes are included in the per diem rate when performed at the group home.

Radiographs

The IHCP limits reimbursement of a full-mouth radiograph series (D0210) or panoramic x-rays (D0330) to one set per member every 3 years.

Bitewing radiographs are limited to one set per member every 12 months. The IHCP defines one set of bitewings as four horizontal films (D0274 or appropriate combinations of D0270, D0272, and D0273) or seven to eight vertical films (D0277).

405 IAC 5-14-3(3) limits intraoral radiographs to one first film (D0220) and seven additional films (D0230) per member every 12 months. Claims billing more than one first film in a 12-month period will be denied with EOB 6243 – *D0220 is limited to one film every twelve months*. Claims billing more than seven additional films in a 12-month period will be denied with EOB 6231 – *D0230 Intraoral-periapical-each additional film is limited to seven films per twelve months*.

Bitewing and intraoral-periapical radiographs are not covered for the same date of service as a full-mouth complete series of radiograph images. The complete series is inclusive of bitewing and intraoral-periapical radiographs.

Table 13 summarizes these reimbursement limits for radiograph services.

Table 13 – Radiograph Unit Benefit Limits

Age	Unit Limits
Full-mouth radiographs/panoramic x-rays	One set per member every 3 years
Bitewing radiographs	One set (four horizontal films or seven to eight vertical films) per member every 12 months
Intraoral-periapical radiographs	One first film and seven additional films per member every 12 months
<i>Note: Bitewing and/or intraoral-periapical radiographs are not reimbursed for the same date of service as a full-mouth complete series of radiograph images. The complete series is inclusive of bitewings and intraoral-periapical radiographs.</i>	

The IHCP limits reimbursement of procedure code D0240 – *Intraoral – Occlusal radiographic image* to two units per member per day. Each occlusal film provides a more extensive view of the maxilla and mandible and reveals the entire arch of teeth in either the upper or lower jaw.

The IHCP covers procedure code D0340 – *2D cephalometric image – acquisition, measurement and analysis* only for orthodontic services and limits it to provider specialty 273 – *Orthodontists*.

Temporomandibular joint (TMJ) arthrograms, other temporomandibular films, tomographic surveys, and cephalometric films are not covered in a dental office.

Restorations

Treatment of dental caries with amalgam restorations, resin-based composite restorations, or stainless-steel crowns is a covered IHCP service. The use of pit sealants on permanent molars and premolars only is a covered service for members under 21 years of age; there is a limit of one treatment per tooth, per lifetime.

The IHCP covers anterior and posterior resin restorations. However, the IHCP reimburses for posterior resin restorations at the same rate as amalgam restorations. IHCP providers should bill for resin restorations only when decay has penetrated the dentin. If only the enamel is affected, providers should bill the procedure as a sealant (see the [Sealants](#) section). Dental providers are responsible for maintaining documentation that supports the level of dental decay and the procedure performed when billing these services.

Note: Margination of restorations and occlusal adjustments are not separately reimbursed.

Multiple Restorations on the Same Surface

For multiple restorations on the same tooth, using the same material on the same surface of a tooth, without involvement of a second surface, on the same date and by the same dentist, the IHCP processes the restorations as a single-surface restoration. The IHCP reimburses for multiple restorations involving only one surface as a single-surface restoration.

For example, for a one-surface amalgam restoration (D2140) billed multiple times for tooth number **14** for the same surface **O**, the same date of service, and by the same provider, the IHCP reimburses once at the *lower* of the submitted charge or the maximum fee allowable for that procedure.

Multiple Restorations on Different Surfaces of the Same Tooth

When billing for restorations performed by the same dentist, on the same date, on the same tooth, using the same material, the dentist must use the single CDT code that appropriately identifies the total number of unique surfaces restored. For example, for an amalgam restoration of a tooth, the dentist would bill either D2140, D2150, D2160, or D2170, depending on whether the restoration was for one, two, three, or four or more surfaces of the tooth. The claim detail must identify the tooth number and list all affected surfaces.

Providers can count each surface only once when selecting the code identifying the total number of unique surfaces. Reimbursement can never exceed the maximum fee for a restoration of four or more surfaces when providers use the same material.

For example, if a dentist performs an amalgam restoration on two surfaces of the same tooth on the same date, and bills the restorations as two separate line items, each using D2140 – *Amalgam-one surface* for tooth number **30** (the first for surface **D**, and the second for surface **O**), the IHCP pays the first line item only. The second detail of D2140 for tooth 30 (surface O) is denied with EOB 5000 or 5001 – *This is a duplicate of another claim*. For reimbursement of *both* restorations, the provider must submit an adjustment to the paid detail line, correcting the restoration code from D2140 – *Amalgam-one surface* to D2150 – *Amalgam-two surfaces* and listing both surfaces **D** and **O** within the single detail line. The IHCP reimburses the claim at the *lower* of the submitted charge or the maximum fee for a two-surface amalgam restoration (D2150).

Multiple Restorations Using Different Materials

For multiple restorations on the same tooth, using different materials, which involve the same surface without involvement of a second surface, on the same date by the same dentist, the IHCP processes the restorations as a single surface restoration for *each material*. **Providers should rarely experience situations requiring multiple restorations using different materials on the same tooth, and the IHCP may review such claims for medical necessity because of the use of the different materials.**

For example, for tooth number **30**, if the provider bills a one-surface amalgam restoration (D2140) for the **B** surface and bills a one-surface resin-based composite restoration (D2391) for the **B** surface, the IHCP reimburses once for D2140 and once for D2391.

Sealants

Pursuant to 405 IAC 5-14-5, the IHCP covers sealants for molars and premolars for members less than 21 years old, and limited to one per tooth, per member, per lifetime. The IHCP does not cover sealants for members 21 years old and older. Benefit limit information is available on the eligibility verification system, indicating tooth numbers to which sealants have already been applied (see Figure 1).

Figure 1 – Sealant Benefit Limits Displayed on the Portal Eligibility Verification

Limit Details		
The Dollar Limits and Service Limits may not reflect recent claims.		
Service Limits	Limit	Remaining
6225 ONE SEALANT PER TOOTH PER LIFETIME - Sealant applied	3, 14, 19, 30	-

The *American Dental Association Current Dental Terminology* is the current coding reference for dental providers. The ADA distinguishes a **sealant** from a **preventative resin restoration** as follows:

“If the care is limited to the enamel, it is still considered a sealant. If the decay penetrates the dentin, then this is considered a restorative procedure.”

IHCP providers should bill for resin restorations only when decay has penetrated the dentin. If only the enamel is affected, providers should bill the procedure as a sealant. Dental providers are responsible for maintaining documentation that supports the level of dental decay and the procedure performed when billing these services.

Sedation for Dental Procedures (Dental Anesthesia)

The following sections provide information about IHCP coverage of the following types of sedation for dental procedures:

- General anesthesia
- Inhalation of nitrous oxide
- Intravenous (IV) moderate (conscious) sedation
- Nonintravenous conscious sedation (monitored sedation for children)

The IHCP restricts reimbursement for dental anesthesia to **one type of sedation** per member per date of service. For example, general anesthesia may not be billed and reimbursed for the same date of service as inhalation of nitrous oxide, intravenous conscious sedation, or nonintravenous conscious sedation.

The CDT dental anesthesia codes associated with each type of sedation are included in Table 14. Note that the reimbursement restriction to one type of sedation per date of service does not apply to codes billed for the same type of sedation:

- D9222 and D9223 may be reimbursed for a member on the same date of service.
- D9239 and D9243 may be reimbursed for a member on the same date of service.

Additionally, as indicated by the asterisks in Table 14, reimbursement for dental anesthesia codes D9222, D9230, D9239, and D9248 is limited to **one unit** per member per date of service.

Table 14 – Types of Dental Sedation (Limit One Type per Date of Service)

Type of Sedation	Procedure Code	Description
General anesthesia	D9222* and D9223	Deep sedation/general anesthesia – first 15 minutes Deep sedation/general anesthesia – each subsequent 15 minute increment
Inhalation of nitrous oxide	D9230*	Inhalation of nitrous oxide/anxiolysis, analgesia
Intravenous conscious sedation	D9239* and D9243	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment
Nonintravenous conscious sedation	D9248*	Non-intravenous conscious sedation
* Dental anesthesia codes limited to one unit per date of service per member.		

General Anesthesia for Dental Procedures

The IHCP reimburses for general anesthesia provided in the dentist's office only for members younger than 21 years old.

The IHCP covers general anesthesia for members 21 years old and older only if the procedure is performed in an inpatient or outpatient hospital setting, or in an ambulatory surgical center (ASC). When the service is performed in a hospital or ASC setting, providers may not bill the CDT procedure code. Instead, the appropriate CPT code must be billed on a professional claim (CMS-1500 claim form, Portal professional

claim, or 837P transaction). Prior authorization is required for general anesthesia for members 21 years of age or older.

Documentation for general anesthesia for adults or children should include why the individual cannot receive necessary dental services unless the provider administers general anesthesia. The provider must retain documentation in the member's file for at least 3 years.

The criteria for coverage of general anesthesia for dental services are as follows:

- Mental incapacitation (such that the member's ability to cooperate with procedures is impaired), including intellectual disability, organic brain disease, and behavioral problems associated with uncooperative but otherwise healthy children
- Severe physical disorders affecting the tongue or jaw movements
- Seizure disorders
- Significant psychiatric disorders resulting in impairment of the member's ability to cooperate with procedures
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication

For more information about anesthesia, see the [Anesthesia Services](#) module.

Nitrous Oxide

The IHCP covers nitrous oxide analgesia only for members younger than 21 years old.

Intravenous (IV) Conscious Sedation

The IHCP provides medical reimbursement for intravenous sedation in a dental office when provided for oral surgery services only.

Prior authorization is required for IV sedation for members 21 years of age or older.

Nonintravenous Conscious Sedation (Monitored Sedation for Children)

The IHCP reimburses for monitored sedation for children, provided in the dentist's office, for members younger than 21 years old. Monitored sedation is the administration of subcutaneous, intramuscular, or oral sedation, in combination with monitoring the patient's vital signs.

Providers should bill this service using service code D9248 – *Non-intravenous conscious sedation*. The IHCP does not cover nonintravenous conscious sedation for members aged 21 years or older.

Services Provided outside the Dental Office

Per 405 IAC 5-14-14, the IHCP reimburses covered services provided outside the dental office at the amount allowed for the same service provided in the office. It is not appropriate for providers to bill the IHCP or the IHCP member (or member's family) an *additional* charge for performing covered dental services in a hospital or surgery center setting.

Dental services provided to members in an inpatient hospital, outpatient hospital, or ambulatory surgical center (ASC) setting (after obtaining authorization) must be billed as follows:

- **Dental-related facility charges** must be billed on an institutional claim (*UB-04* claim form, Portal institutional claim, 837I transaction).
- **Dental-related services** provided in an inpatient, outpatient, or ASC setting can be billed with CDT codes on the *ADA 2012* dental claim form or electronic equivalent.

- All other associated **professional services**, such as radiology and anesthesia, as well as ancillary services related to the dental services, must be billed on a professional claim (CMS-1500 claim form or electronic equivalent).

Note: An exception to this guidance is that physician-administered fluoride varnish (procedure code 99188) is allowed in the outpatient facility setting when billed with the appropriate revenue code on the institutional claim. See the [Physician-Administered Topical Fluoride Varnish](#) section.

Prior authorization is required for all dental inpatient admissions. See the [Inpatient Hospital Services](#) module for dental admission indicators.

Physician-Administered Topical Fluoride Varnish

The IHCP covers physician-administered topical fluoride varnish for members from the time of first tooth eruption until the age of 4 years. Coverage requires the service be provided by or under the supervision of a physician. The IHCP recognizes the following provider types as eligible to render the service:

- Physicians
- Physician assistants
- Advanced practice registered nurses

Before performing and billing for this service, eligible providers are required to complete a certified training course.

Physician-administered topical fluoride varnish should be billed using Current Procedural Terminology (CPT^{®2}) code 99188 – *Application of topical fluoride varnish by a physician or other qualified health care professional*. This service must be billed on a professional claim form or, if the service is performed in a hospital or other outpatient facility setting, on an institutional claim form in conjunction with the appropriate revenue code.

Reimbursement is available for one physician-administered topical application of fluoride every 6 months per member. Billing for CPT code 99188 will not affect dental benefit limits.

Space Maintenance

Space maintenance in children with deciduous molar teeth is a covered IHCP service. Space maintenance for children under 3 years of age requires PA. Space maintenance for missing permanent teeth requires PA. Adjustment to space maintainers, bands, and all other appliances included in the reimbursement for the service and may not be billed separately. All requests for PA will be reviewed on a case-by-case basis.

For all bridge devices and space maintainers, providers must indicate the tooth number for the tooth to which the device or appliance is cemented (the abutment tooth) on the *ADA 2012* claim form or its electronic equivalent.

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